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ABSTRACT

This paper summarizes the proceedings of a 1999 symposium on mental health in infants and toddlers, particularly the role of attachment, held at the University of Minnesota. Presentations by Kathryn Barnard of the University of Washington and Anne Gearity of the University of Minnesota are included. Following an introduction and conference overview, the paper presents Barnard's comments, "High Risk Families: The Emotionally Unavailable Parent and the Child," which assert the central importance to the infant of a secure attachment with the primary caregiver, and discusses a list of indicators to use in assessing emotional connection between primary caregiver and child. This paper also reports figures from the literature and from Barnard's own research that indicate that significant numbers of parents, especially among low-income families, have a history themselves of such insecure attachments that they cannot establish the critical emotional connection with their own children or with other helping adults. The paper discusses the attachment interview used to assess adult attachment and discusses interventions that may help caregivers, and thus protect their children's development. Gearity's presentation, "Response: Observations from the Field," discusses the importance of the attachment function in helping people tame traumatic experiences so that the trauma does not interfere with learning. This paper explains that unless there is a reparative process that helps insecurely attached parents to process old traumas, they will not be available for their child to form a secure attachment with them. This new learning must be provided with an affective component rather than purely cognitively. The paper also offers comments on child protection's role in

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this process. The proceedings also include a question/answer session, a panel commentary, closing comments, and conclusions. (EV)

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The Fragile Early Years:

Assessing the Mental Health of Infants and Toddlers

A Summary of Proceedings of the Symposium held
September 30, 1999 at the University of Minnesota

Edited by Esther Wattenberg

The Symposium was developed in cooperation with the
Irving B. Harris Training Center for Infant and Toddler Development,
the Center for Early Education and Development,
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Cover photo by Nancy Conroy.

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Introduction

Esther Wattenberg
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The importance of the early years of a child's life has come into sharp focus with three independent but interrelated factors. First, we are in the midst of renewed attention to the concepts and research findings in attachment provided by child development specialists: the process of the unfolding relationship between caregiver and infant which primes the child for decisive life-shaping behaviors such as confidence, optimism, the zest for learning, and the capacity to develop secure and reciprocal relationships. Second, neuroscientists have alerted us to the extra-ordinary brain development that occurs in the first years of a child's life. Rapidly developing findings from the explosion of brain research has impressed upon professionals the critical importance of development during the first three years of life. It is during this time that the physiology of the brain is developed and refined—a physiology which will influence the course of the individual's life. Third, the child welfare system is directed, in recent legislation, to pay attention to the early critical years in order to fulfil the mandate of a safe and permanent placement for those vulnerable young children in high risk families who come to the attention of child protection through reports of abuse and neglect.

With the passage of the Adoption and Safe Families Act, 1999, (P.L. 105-89) and the recommendation that concurrent planning be instituted (working intensively toward reunification for a child who has been removed from the family and simultaneously developing an alternative permanent plan for a child through a foster/adoption placement), we are now compelled to pay attention to the critical period of children ages 0 – 3.

This context compels us to grasp the complexity of early childhood developmental issues. Are we prepared with the observational skills to assess infant and toddler mental health? Do we have the capacity to carry out sound case planning with families facing a time-limited rehabilitation period under P.L. 105 – 89 with the principle of "the best interests of the child" as the guide for decision-making? This is today's great challenge to our child protection systems.

In the fall of 1999, the Center for Advanced Studies in Child Welfare brought Kathryn Barnard, R.N., Ph.D., University of Washington, and Anne Gearity MSW, Licensed Independent Social Worker, Adjunct Professor, School of Social Work, University of Minnesota, together with professionals from the community to examine this challenge, to hear from Barnard and Gearity of the research, wisdom and experience they have to contribute to this discussion and to open a conversation with the practitioners in the audience.

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Conference Overview

While a child certainly arrives with his or her own temperament and capacities, the person he or she will become depends on how the environment interacts with those capacities. As such, Barnard proclaimed the central importance to the infant of a secure attachment with the primary caregiver. She articulated her statement about infants.

> "They need a relationship with a caring adult in which there is close monitoring of the infant and close physical contact that provides proximity of the caregiver to the child for at least the first six months.
>
> The caregiver needs to monitor the infant's behavior and be responsive to hunger cues, to tiredness, to excitement, and to overstimulation. The caregiver and infant need to develop a system of reciprocity, looking at each other, talking to each other, touching each other and exchanging affects of pleasure, surprise, disappointment, sadness, but mainly pleasure in the first year. If you don't see that, if you want to protect infant mental and emotional development, you've got to change the environment for the infant."

In these proceedings, Barnard articulates a list of indicators to use in assessing emotional connection between primary caregiver and child: proximity; eye-to-eye contact; responsiveness of the caregiver; predominantly positive emotion during the first year; and information sharing by the caregiver with the infant.

She reports figures from the literature and from her own research that indicate significant numbers of parents—especially among low-income families —that have a history themselves of such insecure attachments that they cannot establish the critical emotional connection with their own children, or even with other helping adults. In these proceedings Barnard discusses the attachment interview used to assess adult attachment and she provides specific figures on distribution by economic status. Barnard also discusses interventions which are helping or have the potential to help caregivers and to thus protect their children's development.

Ann Gearity continued the discussion of attachment. She tells us that the attachment function is critical because it helps people tame traumatic experiences so the trauma does not interfere with learning. "Children are traumatized, and their attachment objects help that trauma move from present anxiety to past memory," she explains. Without this experience of attachment, the trauma cannot be managed and designated to the past. Instead, it remains felt as if it is occurring in the present and interferes painfully with subsequent learning or mastery.

Parents who did not have the benefit of the attachment function to tame their own traumas cannot perform that function for their children. In fact, looking at their own children can be such a powerful reminder of their own painful past that it can become a post-traumatic trigger. The thought of being a child is so painful that they remove themselves from the child.

This has important implications for programming. Unless there is a reparative process that helps the parents to sufficiently hold their old traumas, they will not be available for the child to form a secure attachment with them. Thus we must find a way to help the adult reconstruct a model of parenting that is different from the one he or she experienced. Furthermore, because behavior is learned involuntarily and is reactive and nearly autonomic, this new learning must be provided with affective charge.

Gearity explains in these proceedings that, because behavior is learned involuntarily—absorbed—the memories of a young child are encoded, and embodied, in the pre-verbal and pre-conscious functions. Therefore they are often more powerful than verbal memory and cannot be easily moderated, except within the attachment-containing context. When a parent cannot provide this attachment function for a young child, the child's systemic development is disrupted and his or her psychological structure is compromised.

Gearity offers these comments on the child protection role:

- The investigative function is necessary, but will never be sufficient intervention for the majority of parents who are chronically neglecting, and can even be harmful.

- Case plans that recommend parent education/parenting classes/anger management classes are often inadequate in and of themselves. Cognitive interventions don't work when the problem is affective arousal and pain. Intervention plans must take into account an understanding of: what is causing the parent not to function; what impact this has on the child, based on developmental needs; and what help can best motivate this parent to try new learning.

- There needs to be modeling for the parent, because other ways of caring for a child may not be in this parent's experience, and because we all learn by imitation and experience long before we use our brains cognitively.

- There must be supplementation by other adults, because the baby needs to have alternative avenues of stimulation.

- The parent's ambivalence must be addressed early and directly, because there is a narrow window of opportunity before this tension turns into a more pervasive and unremediated indifference.

- Child protection workers must know normal developmental markers because, when collecting "observable behaviors," it is critical to have an hypothesis about what to observe and what the observations say.

- It can be very helpful to "split the tasks" by using clinicians who are skilled and willing to provide interventions, training, and consultation. The more we know about how to best engage and assess the prognostic course of intervention, the better we will get the process started.

- Because parents almost universally wish to love and be loved by their baby, and to recreate their own fantasy of how they wished their early care would have been, the parent is in crisis when this falls apart. Psychologically, we are more able to engage with a person in crisis.

High Risk Families: The Emotionally Unavailable Parent and the Child

Kathryn Barnard, Professor of Nursing and Psychology;
an affiliate with the Center for Human Development and Disability
University of Washington

Kathryn Barnard introduced her remarks by noting that her presentation would concentrate on certain problems in the parent/child relationship: specifically the parent failing to protect the child; being consistently cold or hostile to the child; attributing malignant motives to the child's behavior; and the child being unresponsive to the caregiver or the environment. She would also address how the environment interacts with the child and how the child influences the greater environment.

Barnard emphasized that a secure attachment is a life-long protective factor and develops out of an emotional connection between caregiver and child. "There's just a lot of evidence in the literature that if a child develops a secure attachment with a primary caregiver, life is going to be better all along its course.... In the normal population we find about 75percent of children develop a secure attachment. In high-risk populations it's about 50 percent, and I'm finding in poverty families it's only about 25 percent." How does a secure attachment develop? she asked. "It's by that emotional connection, having someone close to you respond to your needs and not do it on Saturday/Sunday, but do it at eight o'clock on Monday morning, 8:30 on Monday night. The child begins through all of these periods of interaction to get the sense that they're safe and cared for and they can go on to exploration. ...a goal for us to think about then is how we can help children be secure."

She offered a list of indicators to look at in assessing whether there is an emotional connection between a parent (or other caregiver) and child.

<u>Proximity.</u> Barnard said an attempt to maintain proximity by both parent and child is an important indication of connection. Proximity also promotes the emotional connection and so contributes to a secure attachment on the part of the child.

Barnard discussed a study done by Elizabeth Anisfeld at Columbia Presbyterian Hospital (1) that suggests the importance of proximity in developing secure attachment. Anisfeld worked with mothers in Harlem who were randomized into a group that was given a cloth baby snuggly and a group that got a plastic infant seat. After a year, the rate of secure attachment in babies of mothers given the cloth carriers was about 85 percent and in the infant seat group about 37 percent. "I was out to buy snugglies for everybody in Seattle," said Barnard. "If you think about attachment theory for the young baby who can't walk and talk, being near an adult caregiver is one of the best ways for that baby to have a chance to develop that sense of security."

<u>Eye-to-eye contact.</u> "Can the child and the parent or caregiver maintain eye-to-eye contact?" Eye-to-eye contact is a very powerful means of connecting emotionally, and young babies and their parents violate a lot of communication rules that people maintain in adult communication. For instance, Barnard commented, "some people will tell you that American Indians do not make eye contact with their children, but this is primarily true of others and the child. It is not true of the parent and the child." She also said research has shown that adults never talk at the same time and have

effective communication, "but parents and babies talk at the same time together, and it's quite all right and effective."

Responsiveness. Children need to learn that their environment is meaningfully responsive to them. When families develop no contingent responsiveness, children can't learn effectively how their behavior is triggered by or affects their environment.

Positive emotion. Predominantly positive emotion during the first year reflects a good emotional connection. UCLA psychologist Shore (2) has written about brain and emotional development, said Barnard. "He states, and I affirm from my own observations, that the predominant emotion during the first year of life should be positive. If you see a lot of negative emotion during the first year of life, …something is wrong with the emotional connection." He also says that during the second year of life there is a lot of negativity. "There is such rapid brain growth that the wiring system is like the worst traffic jam you would see in St. Paul or Minneapolis. Babies' brains can't hold all of the information they are taking in, and they are 'terrible'. And that's one of the things that's associated with negativity." Barnard said Shore notes that young children cannot get themselves out of this negative affective state. The major role of the caregiver in the second year of life is to help children get out of negative emotions so they do not "get stuck in them," she said. "We're learning that…the wires and the signals that don't get used very much [during the second and third years of life] die off. If a child doesn't experience a lot of positive emotion, the chances are that their capacity to even process positive emotion in their later life will be diminished."

Information sharing. The only way babies have to learn about their world is through their caregiver, which is accomplished through information sharing. "The adult does a lot of mediation, stimulation, and information exchange," explained Barnard. "All we know about early brain development is the more those wires and neurons are stimulated to develop, the more the child is going to have the use of the cortex of his brain rather than operating on the hind brain." She noted that, because the hind brain doesn't allow executive control, people are permanently stuck with impulse acting if they are operating out of the hind brain.

She also pointed out that babies learn how to pay attention…to attend…through intimate contact with their care provider. "The first thing I notice in children of high-risk families when they get to school is they cannot concentrate and attend. This ability to attend starts early."

Unless we support brain development in the early years, how can we ever expect to ensure a receptive basis for public education? she then asked. Barnard told of having what is called "the Brain Squad" in Washington. The state trained about a hundred and eighty people to go out and talk to citizenry about brain development. Legislators are being bombarded by their clients regarding what is being done on this issue and now legislators are looking at putting more resources into early development.

"Now I'm going to switch a little bit to tell you what we've been finding in working with families," she continued. "But first let me review for you… *This is my…statement about infants. [They] need a relationship with a caring adult in which there is close monitoring of the infant and close physical contact that provides proximity of the caregiver to the child for at least the first six months.* If you don't see that, if it can't be available, you've got to do something."

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"The caregiver needs to monitor the infant's behavior and be responsive to hunger cues, to tiredness, to excitement, and to overstimulation. The caregiver and infant need to develop a system of reciprocity, looking at each other, talking to each other, touching each other and exchanging affects of pleasure, surprise, disappointment, sadness, but mainly pleasure in the first year. If you don't see that, if you want to protect infant mental and emotional development, you've got to change the environment for the infant. The caregiver needs to scaffold the environment so that the infant can process sensory input, have a chance to develop things like protective balance reflexes, to experience non-nutritive sucking, to feel the texture of objects and of food."

"The majority of caregivers in our society can provide this type of experience for their young children. However, there are caregivers who are depressed, lonely, in conflict, non-intuitive or inexperienced, who cannot provide this experience for their infants." Barnard said that thirty percent of parents who are defined by being in poverty are not able to provide this regulation assistance, or to scaffold the environment, as the baby needs it.

Barnard discussed findings regarding attachment from her work with high-risk families. She talked about a study of adult attachment classifications done in conjunction with a research partner, the Early Head Start program. (3). Researchers hypothesized that people don't use the services they have available because of problems in their own past relationship histories. "They have child care. They have parents' classes. They have home visits. They have food banks. They have everything at the center and yet, some parents who are enrolled don't use these services. Why?"

To assess the caregivers' attachment history, researchers used the Adult Attachment Interview (4), which asks a series of questions to elicit the adult's life story, questions that examine the mother/child relationship such as: What was your childhood like? Can you give me several adjectives that would describe your mother? Could you tell me a story about why you used that adjective? The answers are then coded to produce attachment classifications.

Categories of insecure attachment include:

Dismissive. "In their early childhood, their mother, father, or other caregiver was not very responsive to them when they wanted help, and they learned to go on their own. They're the kind of client, when you see them, you'll say, 'How can I help you?' and they'll say, 'I don't know.' 'Well, are you having problems with your housing?' 'No.' 'Are you kind of concerned about needs of your children?' 'No.' … they acknowledge no problem. It's really hard to be helpful to somebody who doesn't have any problems…they have learned in their childhood that, if they're bright and shiny and not crying, they get more attention from their caregiver. And so that's the way they behave in their adult life; they put on the good side when they're confronted with a helper. They minimize the role relationships have in their life, and they usually don't have many close friends."

Preoccupied. They "are just consumed with talking about their relationship with their attachment figure, their mother…" They are sometimes described as having a neurotic-type personality.

Unresolved. This is where the adult shows disorganization in his or her thinking, at times disorientation. "You ask them to give you a story, or you're looking at the chronology of their childhood. As a listener, it doesn't make sense, it doesn't fit together and they have lapses in their stories."

We see in studies of middle-income, college-educated people that about 55 percent have a secure attachment history, said Barnard. Among low-income people, the figure is about 39 percent. Among the clinical population only about 8 percent have a secure attachment history. In the Early Head Start program (where one must be poor to get in), about 24 percent or 25 percent had a secure attachment.

Figures for insecure attachment are as follows. For the dismissive category, 16 percent of middle-income, college-educated people fit the criteria. Among the low-income it's higher, 25 percent, among the clinical population, it is 26 percent; and among the Early Head Start population it was 35 percent. For the preoccupied category, among the middle-income, college-educated the figure is 9 percent, among low-income it is 8 percent, among the clinical population it is 25 percent, and among the Early Head Start population it was 7 percent. For the unresolved and unclassifiable category, the incidence is about 19 percent or 20 percent for the middle-income, college-educated, 28 percent among the low-income, 40 percent among the clinical population, and, said Barnard, in the Early Head Start population we saw about 33 percent.

"Now we knew, as we were looking at the program, that some of the families were not with the program so to speak," said Barnard. "About a year and a half into the program, when families had been there for at least a year, we asked the home visitors who were trained in child development to identify families that they found very difficult to work with, who weren't really participating in the program. ...we couldn't identify these [hard-to-engage families] from any other indicators that we had—from baseline depression scores, IQ, education level, mastery, protocol, or the relationship questionnaire that we used." However, noted Barnard, predominant was their classification in the adult attachment interview. Sixty percent of them were in the category "unresolved, unclassifiable."

The thing that is usually seen in the history of this category, explained Barnard, is a woman who has had a lot of trauma and stress, been raped, been a victim of violence, had losses of significant caregivers, but had not resolved the trauma or loss. "I had this first dramatically presented to me when one of the home visitors brought in a videotape. ...She said, 'Here, solve this.'" The videotape showed a mother standing, looking at a five-month-old baby in a plastic infant seat. The mother was giving the baby the bottle, but looking around, not even looking at the baby. She had taught the baby not to move its hands during feeding. "So here is this little five-month-old baby," continued Barnard, "had its hands folded right in front of him, sucking on the bottle, desperately trying to get his mother's attention. And the home visitor said, 'What shall I do?' ...I looked in the mother's eyes and I thought: there's no way this mother can be emotionally responsive to this baby. But I didn't understand why. So I went back to the office and I got out her record of the Adult Attachment Interview. I read her record and I understood. This mother had been raped almost nightly from the ages of three to six by her father. Three of her family had been violently murdered. She felt she was the potential victim of violence. She had flashbacks of this violence. She could not go to sleep at night. She locked her doors and windows every day. She put a davenport in front of her doorway. She would not let her child play on any objects when he got to the age he could walk because she was afraid he would get hurt. We tried to get her involved in some parents groups. She went once. She said everybody talked about her there and she wouldn't go back again. We tried to get the child into child care. She would not let the child be cared for by anyone else because she felt the child would experience the same trauma she had experienced as a young child.

"We have learned over the last three years…that there is a significant impairment in some mothers' ability to become parents, and how we work with this is a big challenge." University of Washington doctoral student JoAnne Sochany did a qualitative analysis of the adult attachment interviews, and found that "pretty much these women [in the unresolved category] describe themselves as motherless daughters. They felt they had no mother. The women would talk about how they tried to find out when their mother left them. Many reported their mother would go for three or four days and then come back. During the time after they got put to bed, they knew their mothers went out, so they would trap the mothers. They would put [for instance] a little knife in a door. They knew if it had moved their mother had gone out during the night. They essentially reported that they really felt that they were all alone; they had no person in their early environment to protect them; they had no love; environments were chaotic. One mother used the phrase, 'In my family, no children were allowed.'"

"What you see in these mothers who had not resolved issues of trauma or loss, loss of their own childhood, is that they are unable to emotionally relate with their babies and with the caregivers. The caregivers describe making home visits; the mother will not even say 'Hello.' She won't say, 'Sit down here,' but she'll maybe go off into another room, be there for half an hour, come out. She's dressed herself, dressed the baby and walks out the door. So very little communication. …(Incidentally, people who are making transitions to learning how to parent have a tendency to want to tell other people about it before they can try it themselves.)"

Barnard showed a video clip of a classic attachment experiment in which the connection between mother and child is observed as both a mother and a stranger come and go in a room where a child is playing. As she showed the video, she narrated, "the mother and child are playing together. See it's rather interesting. …one of the things that's quite characteristic of this child, we haven't seen in the children we've been testing, is that this child frequently backs up. We wondered about this mother's fear about her own physical safety. She's usually looking ahead. Is this something the child has picked up as a way of being? You know, as you walk away from things, you never leave places uncovered?"

"…[The mother] is looking at him and now the stranger has come in. They both look at the stranger and it doesn't really disrupt much of what they do. You see this motoric disorganization, which is very characteristic of these children. This child at 15 months is very primitive in his play. He picks up and feels objects and kind of drags them around, but he doesn't really do anything with them. He may bang them a little bit, but that would be more a 5-6 month age level. You get the feeling of an emotional connection? You get the feeling that the baby is trying to seek proximity to the mother? Certainly more him than her. We're seeing kind of neutral emotions or kind of motherly pouts, aimless wandering, knocking into things."

"Now when she goes, we'll want to watch what notice he takes of that. Many times the insecure child doesn't care when the mother leaves. He may or may not take note of it. The stranger asks the mother a question, so again this mother gives a lot of visual surveillance to the child. The stranger tries to engage the child in some play before the mother's going to leave. He turns away. There's a mirror there. He's looking in the mirror. So he's not able to explore his environment in a novel situation, and the next drive that replaces secure attachment is to explore your environment. He's really kind of wound up in his disorganization; he can't depend on anything, so he can't go on to explore. He can't learn."

"Now the mother's leaving. He notices the mother goes. He looks right toward the stranger, then back at the door where the mother went, and then he gets himself another toy and engages in a little bit of show of anger, knocking the simple-type objects together. He energizes himself while the

mother is out of the room to be a little bit more playful. Whether he's looking at himself or trying to figure out what's going on here, he's looking in the mirror. Now it's interesting. Without the mother in the room he's not as motorically clumsy, but that's the only thing I notice. I think his play is still very primitive. The stranger tries to engage him in some playfulness. He takes her lead, which is good, and he becomes interested in this toy with which she has caught his attention, pulls it around, likes to investigate it a little bit. So the stranger told him, 'Good job.' It certainly got him up on his feet again pulling that object."

"This child in our observations has been severely neglected and rejected by his mother. These are the kinds of children that we begin to see as they get older are very aggressive, very angry. [Barnard added as an aside, "I agree with what Bruce Perry (5) says about abuse and neglect—that of all the conditions that children need to survive in, neglect is the most damaging to the brain."] Okay, the mother's come. He turns around. He looks at her. She, interestingly, sits down with him. When she does, he turns his head down and continues playing with the object and moves away from her. He really doesn't have any pattern for dealing with the stress of separation."

"When we tested this child at 15 months, his Bailey mental score was 77, and at 24 months of age, his score was 55. Unless something remarkable happens in the care of this young child, he probably is going to become more and more of a problem as he gets into school and as he gets to be a teenager and as he spends time in prison, probably for the rest of his life. So our challenge, yours and mine, really is: how are we going to turn some of this around? What we're doing right now is not working. We've got to learn how we can provide environments, with or without the parents, that are going to support the emotional connections that young children need so that they can go on to develop all the parts of their personality, emotions and brains that will help them to live in the complex world you and I barely survive in on a daily basis."

Response: Observations From the Field

Anne Gearity, MSW, Adjunct Professor,
University of Minnesota School of Social Work,
therapist, consultant.

Anne Gearity began her response by emphasizing Barnard's statement that about 30 percent of the parents in her Early Head Start study had an experience of loss and trauma that remains so present that they could not engage with their babies or with other adults who were offering help. "This is very significant," said Gearity. "By using the adult attachment interview, she is helping us to see that attachment is not a moment in time. It's not a tangible entity. It's not a bonding like some glue. Rather, it's a process that permits internalization and psychological functions to be constructed in the service of survival. In her research she is telling us that parents who have not had a sufficiently reliable attachment experience, which serves to contain or facilitate the taming of these experiences of trauma and loss, never get [the trauma] resolved into memory."

"Children are traumatized, and their attachment objects help that trauma move from present anxiety to past memory. But these are parents who never had the attachment function to titrate that experience, so it stays ever present. These experiences [of trauma], and the intense states and feelings related to these events remain alive and painfully interfering."

"We have a synergistic understanding of attachment, understanding and memory. In [Dr. Barnard's] population, these memories are not per se memories, but actually daily experienced events. ...If these experiences cannot be held within a secure attachment experience—or these experiences are so often repeated that they stay the dominant remembered past—the person remains in the timelessness of traumatic memory. This causes the present to be a possible and likely continuation of what was. The traumatic memory is actually in the present. It exists, not on September 30, 1999, but in a timeless state of possibility."

Gearity noted Dr. Barnard's comment that the woman in the video stayed with her back to the wall, and her child acted as if he needed to stay with his back to the wall. Gearity observed: "This can be seen as a learned response to the mother's perception of reality, which is: danger can happen at any moment and you better keep your back to the wall. The present reality of a safe room does not change that perception. Now the implications are profound. ...unless there is a reparative process that helps the adult sufficiently hold this ancient memory, the needs of the child can and likely do become the post trauma trigger. Does that make sense? Looking at that child actually becomes a trigger, a post-traumatic trigger of her past memories. That's phenomenal, because we think of having a child as a reparative experience; but for those mothers, you're saying that the ancient memory of maltreatment is so great that the thought of being a child becomes a post-trauma trigger, and they remove themselves from that experience as Kathryn described."

"When there is so much arousal, so much reactivity to pain, very little learning can occur. ...They cannot learn new ways when they are so aroused to the fear of the pain happening again. So we come in with our parent education models, but we have profoundly anxious and avoidant learners. It's

too painful. It is imperative that we find ways to help the adult reconstruct a model of parenting that is different from the one experienced by the adult."

"We're talking about trying to help them in their imagination construct a template that is different from their experience. Even though we know most of us parent out of our experience, we're asking them to construct an alternative template. And this model, again addressed clearly by Dr. Barnard, must be affective before it can be cognitive. It must feel safe and interesting before it can be learned. There has to be something in it for those parents and children."

Gearity pointed out headlines on the cover of *American Psychologist*'s July 1999 issue, "Behavior – It's involuntary." "I love as a social worker to pull up their journal and say, 'I knew it.'," she joked. "What this means is that early behavior is learned involuntary; it's absorbed. This is not a conscious process for many of these parents, but a reactive and nearly autonomic process. We've got to provide the affective experience for the new learning. We have to construct a culture that permits the meaning of the behavior to make sense."

Next she showed a clip from a video done for Voices for Illinois Children, with financial support from the Macmillan Foundation. The video showed new mothers talking about and feeling competent about various stages of parenting. Thirty-five thousand copies of this video, which emphasized the theme "it feels good to know what to do," were distributed to new parents. They are "constantly emphasizing 'if you do this, it will feel good,'" explained Gearity. "I think this is a good illustration of the kind of interventions we have to think about, because unless we can establish something pleasurable in [the parenting] for the mothers, it is too painful a learning process. This will have an enormous implication for the child protection dilemma, because we have to help mothers and fathers feel that it can feel good taking care of a baby, that it's not only painful."

"As a concerned community we are immediately and correctly drawn to the wellbeing of the child. The intention of today is to heighten our awareness to the first three years of life as critical. We continue to hear well-meaning adults comment, 'He won't remember it. He's only two.' He may not remember this verbally, that's true. But memories are encoded and embodied in the pre-verbal...and pre-conscious functions. Therefore they are often more powerful exactly because they cannot be easily moderated, except within the attachment containing context. ...Early memories are actually more powerful exactly because they are not verbally titrated; they can't be talked about. They can't even be remembered in word pictures. They are remembered in body images. They're remembered in sensations. They're remembered in states of arousal. They're remembered in states of unbearable aloneness, and that's the point about motoric clumsiness. [The boy in the video shown by Barnard] is remembering something of his early experience in his developmental inhibitions."

"We are struggling then with the systemic neglect of children, not just the neglect in the parent-infant relationship. We want to think about what happens to the children who are deprived of necessary and essential provisions that permit their own internal systems to function." The child's internal system is compromised.

Gearity then showed an excerpt from a PBS special called *First Feelings*. She said, "What I want you to look at is how the child's internal system, the child's intrapsychic structure, is compromised. (The video shows a baby in an infant seat with his mother talking to him. When she responds to his cues with appropriate stimulation, the baby appears content, smiling, interactive. This is alternated with periods of no response at all by the mother, just an impassive face, when the baby becomes agitated

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and begins to cry.) I wanted to use [the video] here for a particular issue Dr. Barnard is alerting us to…that when we think of these families that we have difficulty engaging, we have to think on many levels."

"First we have to think on the social support level: what can we provide in the environment to maximize families' abilities to make it as parents to their children?

"Second, we have to think of the parent-infant interaction and realize that the parent is an active player in that interaction. She or he brings history that often makes the parent-infant relationship toxic. In addition, the child brings an active experience, both in his temperament and his earlier learning. …The tape [shows] that when the stimulation is not optimal—we're talking about good enough, we're not talking about perfect—when the stimulation is not optimal for learning, the child begins to learn that he cannot maintain regulation. …We can also hypothesize that that flat face [of the mother] can be read by the child not just as abandonment, but anger, rejection, disinterest, disapproval, etc. And now we're into the negative set of emotions that Dr. Barnard cautioned should not predominate in the first year. Unless those are mediated by comparable positive emotions, the child is again probably, like his parent, introduced into a world view that is painful, traumatic, full of loss and unmediated by our good intentions. You start to see the cycle that we are challenged with."

"We want to be very aware as we proceed in our community discussion of how we address mental health, that we're not just talking about the parent as the active player. We're equally talking about the infant as the active player, because unless the child is equally able to engage the parent as the parent is able to engage the child, the system breaks down. How do we help the infant develop in a way that he or she can engage the mother and the father?"

Gearity then addressed child protection roles. "The intent of this forum is to really engage child protection and county-based workers to begin a more active collaboration with the community-based people who are interested in infant mental health," she said. "I think we have an opportunity, and certainly the attendance speaks to this, to take some active initiatives in this area."

First, the investigative function of CPS is a necessary one, but it may also be harmful, Gearity observed. The investigative function is not a complete intervention, and it would never be sufficient intervention for the majority of parents who are chronically neglecting.

Second, case plans that recommend parent education, parenting classes or anger management classes are often inadequate in and of themselves. "I said 'are often' because I was being kind. If I was honest, I'd say, 'Don't use them!' You can't do cognitive interventions when the problem is affective arousal and pain. You're setting people up." She discussed one of her most difficult cases, a child diagnosed with reactive attachment disorder who had a horrible history. "His mother accosted me with this message: 'What do you mean I can't see my child. I have five diplomas from different parenting classes.' She had never spent more than three weeks of consistent care with her son, but she had five diplomas. It had made no impact in her sense of the child. Intervention plans must take into account an understanding of what is causing the parent not to function, what impact this is having and will have on the child based on developmental needs, and what help can best motivate this parent to new learning.…We have to have these questions in our minds when we seek consultation about making a case plan: What is motivating the parent? What impact will it have, and what's going to help the parent change?"

Third, parents need to have alternative ways of caring for children modeled for them. "They don't know the better way to parent. If they knew the better way to parent, they'd do it. You saw on Dr. Barnard's video when a visitor came in and tried to play with the child, the mother did not immediately model. But when she came back into the room, she seemed to have understood that maybe there's a different way to do it. She seemed to have caught on that the visitor sat on the floor so maybe she tries sitting on the floor. If we don't model—since we all learn by imitation and identification long before we use our brains cognitively—parents can't learn."

Fourth, "There needs to be supplementation by other adults. …A baby is eagerly expecting the world to be turned on for him. We must provide alternative avenues of stimulation. Babies come to us with a learned expectation, and our job is to say there can be something different." She pointed out that these parents, when they talk about their children, give a flat description. "How do you get this baby from one-dimensional to a three-dimensional person with needs and energy? How are we going to infuse this baby with energy and pleasure for the parent?"

Fifth, "The parent's ambivalence must be addressed early and directly. We understand the attachment becomes insecure primarily out of the parent's ambivalence. This is not a conscious ambivalence. They're not saying, 'I'm going to choose this,' but 'I don't know how to make this work.' This is the primary source of the present crisis and there is a narrow window of opportunity before this tension turns into a more pervasive and unremediated indifference. If something causes me so much pain, one way to protect myself is to disconnect from that pain. And we see that happening with parents and their babies. If we can understand the reason why, we can speak to it. But we've got to speak to it on the front end. You who are doing CPS work, the content of the crisis is almost secondary to the effect of the crisis."

Sixth, you must have an hypothesis, Gearity said. "It is critical to have a hypothesis about what to absorb and what those observations tell you. CPS workers must have normal developmental markers and make sense of how to use them. We have to provide training about development and what changes in development." In fact, she stressed the need for constant training. "The whole field of child development has changed so radically in the last 25 years. So many of our workers learned about child development a long time ago. It doesn't work any more. We've got to be reading journal articles every month about Dr. Barnard's research and what we're finding, and it's got to be constant."

Here she added what she called her "public service announcement". "There is a growing interest in this community to develop an infant mental health network, and to identify clinicians who are skilled and willing to provide interventions, training and consultations. The more we can be skilled at how best to engage and assess the prognostic course of intervention, and this intervention will likely be long term, the better we can get this process started."

"I think one way of thinking about the six-month rule" she added, "is not [whether] you're going to solve the problem, but to develop a prognostic sense of whether families can change over time. What will help them change over time? And how do we get them motivated to sign on, to hire us to help them change over time? That's what we want to look at."

"The benefit of taking an infant mental health lens is that for most parents, having a baby is inherently pleasurable. There exists an almost ubiquitous fantasy that when I have my baby, I will love and be loved….I will recreate my own unspoken fantasy of early care as I wished it had been so that the process of pregnancy allows me to think about how I wished my parent had taken care of me.

…Psychologically we are much more able to engage with the person in crisis in whatever way we can when we understand that this early wish is present. All of us who have worked in child mental health know that it's a lot easier working with a parent of a five-month-old or a ten-month old or a two-year-old than it is working with a parent of a 16-year-old. There's too much damage."

Gearity ended her presentation by observing that just as parents have trouble "doing it differently," so do human service professionals. "Our systems don't want to change. We have this research, and we come to conferences and we all talk about what we've learned, and then we go back and we slip and do it the old way. …There's a parallel process here. We get mad at the parents for slipping and doing it the old way, but we're doing the same thing. We've been talking about early intervention for a long time and we're doing it the same way. [Today's conference] gives us a way to declare a challenge and find a way to do it differently."

Question/Answer Session

Q. A child care licensing worker for Hennepin County Children Family Services asked if there has been a research study addressing the questions raised at the conference, in the area of child care. She commented, "I see toddlers and infants in my day care homes that are starting out from six weeks to almost high school age. Lately I've been seeing a lot of behavior problems in the [child care] homes and a lot of medication being used at early ages. ...I just want to know if any studies have been done in that area?"

Dr. Barnard responded, saying, "There has been a national study on the influence of child care on infants. The study shows one of the most important variables that predicts their later social, cognitive, behavior development is the primary relationship with their biological caretaker. ...But I don't know if I totally believe that yet. This is what I see in terms of child care. Number one, it's very hard to get anyone who takes care of infants, and those people who do take care of infants generally are unlicensed home care providers and are depressed. So that's a really big issue." She commented that we must all understand that "parents and child care providers need more respect, acknowledgment, training and regard for the job they are doing. Barnard observed that families cannot afford to have both parents not working, and that "corporate America really has robbed the resources from families and we need to claim those in terms of getting business to kick in the dollar to help with child care so that it can be offered in the way that it would be supportive." For instance, she said, if "a child is in a poor relationship with [his or her] own biological parent," good quality child care can reverse the course for that child. Barnard is on a commission for early learning in the State of Washington which is grappling with the child care issue. "It's a big one," she said. "Sixty percent of children under a year old are in child care."

Gearity added that Dr. Barnard had mentioned a study in Israel that looked at the difference in the touching relationship between the parent and the child care worker. They found a quality of difference in the touch. Between the parent and the child there was evidence of touch that was affective. It had a feeling connection. The quality of care between the caregiver and the child was more a working connection. "Now a working connection is not bad, but again, if you follow infant mental health research, more and more of the research leads to the importance of early affective connection." She noted that as a clinician she can feel that something has changed when she's working with a child and there's a moment when she slips in the therapy hour and says 'Oh honey,' or 'Oh sweetie,' or finds herself touching the child, which she doesn't usually do. "I'm aware...ah—the affective connection!" she exclaimed. The huge challenge is how do we help children experience not just a working good quality care but an affective level of care.

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Q. A children's mental health caseworker at a shelter raised a concern about lack of housing in the community. She said "the average stay for people is, in the beginning, about 3 months," but she also knows people who have been in shelter up to nine months, some with children, and they all live in one room. She also noted that many women have children in shelter and wondered about the impact on the other children when a baby is getting all the attention and the nurturing.

Gearity said, "Let me respond this way. In infant mental health, one of the benefits of taking the developmental approach is that it changes the way we talk about mental health. What we're using as mental health is not DSM categories...If you think of the word 'dis-ease,' the opposite of disease is 'at ease.' So when we talk about mental health, we're talking about how to provide necessary ingredients to children so that they can develop in a way that is adaptive, to function in their own best interest, and to allow them to belong to a community. What you raise is what happens when the environmental factors become the pathogen ingredients to dysfunction. Certainly not having a place to live and a mother who has attention for you is a pathogenic ingredient that can create a dysfunction. I think what happens for those children largely depends on how the rest of us interpret the world to them. So again, the charge is not only how do we help parents function the best they can, but how do we provide supplemental functioning to support those children's needs? And how do we identify the chronically unavailable parents who are not going to be able to rise to the occasion? How do we do that in a way that hastens the repair that's necessary? But certainly, the housing crisis is a critical one, because that's an environmental factor."

Q. A fetal alcohol case manager at Eden Women's Program commented, "I guess what really struck me this afternoon was the [idea mentioned on an overhead about] human partnering. I know in the chemical dependency field I've been trained to keep this professional distance, and I don't think that human partnering and professional distance are in the same universe."

Gearity acknowledged, "That certainly raises a huge challenge that clinically we need to address, and you speak it beautifully." She said, "Many of us were trained in neutrality, so how do we use ourselves in a way that satisfies both the obligation of boundaries but also allows us to be?" She noted that Martha Stark, a psychoanalyst out of Boston who has written a book called *Modes and Therapeutic Action,* talks about one-person psychology, two-person psychology and the one-and-a-half person psychology. "I think she would say in children's mental health we do a one-and-a-half person psychology in that we're really talking about how we provide supplemental function until the child can do it for herself. How do we provide the kind of relatedness that the person needs until they can both turn it on themselves and seek out real human partners. ...Now that is a very highly developed skill. And again, I think we want to develop a network of consultants who can help us with that. We're not talking about let's all be friends in the community. It is very purposeful and intentional work to allow myself to be a human partner with an adult who has been so repeatedly disappointed by human partners and do it in a way that will be effective and not harmful. That's a whole new model of clinical intervention, because we do not want to contribute to these adults' pain. But absolutely, we need to develop the skills."

Q. A Hennepin County Child Services worker, noting Gearity's earlier comment that CPS case plans should not depend on parenting education and parenting programs because they are cognitive and not affective, asked how one writes the case plan so we know that affective learning is taking place.

Gearity asked, "Can I just show you an example? You might say the parent should go to a parent education class, period. Right? If your case plan says parents should use parent education classes to demonstrate x, y and z....Parents having gone to parent education classes will spend reliable time with their child and demonstrate some interest in attending to the child's needs....then it's a different case plan."

"If you've got a two-year-old, here's another example. Parent will visit the child every Wednesday at one o'clock because we have a two-year-old who needs to develop object constancy and reliability. ...What I do is mesh child development tests and the reciprocal parent response. Susan Schultz, one of my colleagues, has a lovely handout that she did for one of my classes. She wrote down, 'Here's what the child needs to do; here's what the parent needs to do to help her. Here's a developmental task; here's the steps the parent needs to do. Now we can do some of that pretty accessible language that gives you some way of watching those outcomes, but they're dynamic outcomes. They're interactive outcomes rather than flat outcomes. And that's what we want to live by."

Commentary

Wattenberg then introduced a panel of speakers. First was **Christopher Watson**, coordinator of the Center for Early Educational Development (CEED) in the College of Education and Human Development at the University of Minnesota. Watson began by saying, "We have been given the task to coordinate a framework for infant/toddler mental health services in Minnesota. As you all know, this has been a formidable task. We tried to take the information from excellent researchers like Kathryn Barnard and clinicians like Anne Gearity and meld that into something and deliver it in ways that are useful to you. Part of the reason Kathryn's here today is because we're hosting the Minnesota roundtable tomorrow in Bloomington. Like this event, it's sold out, which is a testimony, I think, to the amount of interest in many professions in this information."

"We're in the third year of our study and of our work on the infant mental health project. We're now at the point where we have found out what kind of resources the State of Minnesota has. We're viewed as a state that has a lot of resources for families, which we do. But we found out there are a lot of things that are missing from the picture, including training, programs, and service delivery that are not necessarily optimal for infant/toddler mental health. In this next year they will look at two communities, to be decided soon, to see at the local level what kind of training people need, how resources can be connected in the communities, and what kind of systematic changes the state can help lead. Minnesota has a reputation for a lot of local autonomy," he observed. "It's going to look different in each community and we're trying to respect that."

The second panelist was **Susan Benolken**, social services program consultant to the Minnesota Department of Human Services. She noted that she works with an infants and toddlers with disabilities program enacted as a title program for families and children since 1986 in Minnesota. "We began to notice, as Anne and Kathryn were saying this morning, that it's the relationship between the family and child that's really important. Each has a responsibility to contribute to that relationship. It is often more difficult for children with disabling conditions to contribute their part of the relationship, or for their contribution to be read in appropriate ways," she commented. Also, most children with disabilities live in the same communities as everyone else does and experience many of the same social difficulties of violence and poverty.

"As we began this journey," she continued, "we started hearing things about kids getting kicked out of not one child care, but two child cares, three, four, at very, very young ages, for behavior. We also were noticing the phenomenon of depression...We tried to see what kind of help there was and figure out how we could be helpful to families. There really wasn't much there....young kids are not recognized as having mental health issues. More resources have been directed toward older children and adolescents, and not many of the resources have been allocated in ways that make sense to families and very young children." The notion of infant mental health she said implies a wellness concept, that children and families need to be aware of ways to help promote healthy relationships. "It's a way of being with people, that whole constructive human partnering that we talked about, a way of listening and joining with families' lack of judgment, trying to facilitate relationships."

The state has joined CEED in a feasibility study to explore how to better support good infant mental health. They are asking questions such as: "What do we need to do? What kind of resources do we need to provide?...What do we need in a human services system? ... Who should take the lead on that? Is it a mental health lead? Is that a public health lead? In Minnesota, could it be an education lead, as education is in the home for these families very early on, particularly in the early intervention program? Who should lead this charge? Who should help develop this system? Is it a medical model? Is it a social services model? What kind of training do people need to be infant mental health practitioners? Do we need infant mental health practitioners, or can we all kind of encompass some of that infant mental health concepts in our interactions with families and children? ...So you get just a small sense of how we need to spend some time trying to figure out the framework."

"We're also looking across our program areas such as chemical dependency, the mental health area, the world of disabilities—all the folks who are working with children with disabilities, trying to again look at the holistic relationship." The goal is to have "a seamless kind of system of early intervention and appropriate mental health activities." They are interviewing communities to gather as much information as possible regarding needs.

The final panelist was **Senator Jane Ranum**, Chair of the Senate Judiciary Committee. Ranum said she would present a legislative context for the issues being raised at the conference. "First of all, for those of you who know nothing or don't want to know anything about the legislature, you need to. If you're frustrated with state priorities and spending, guess who makes the decision? Your senator and your legislator. If you do not know that person, those individuals, you need to. You need to educate them."

She went on to review current concerns of the legislature. "They're concerned about the increasing numbers of mentally ill people who are in our prisons and in our jails. That is very expensive housing for people who have mental health problems. Minnesota spends $323 a day to house people who are incarcerated." She said that if policy makers do not understand, and human services professionals do not educate them about mental health issues of children from the very beginning, Minnesota will, as California did, take money out of higher education and K-12 and spend it on corrections. "... if we are going to make real progress in the next three years in this administration, it will have to come from the grassroots. ...I think you need to understand the political dynamics. There are a lot of legislators...who don't understand the brain research. Their development of children is based on how they came along or how they raised their children. And so if we really want to jumpstart and have public policy based on brain research, there has to be a community dialogue and [the brain squad idea Dr. Barnard spoke about] sounds brilliant."

County boards have no more understanding of these issues than do legislators, and count-level government affects families and children more than state level government does, Senator Ranum said. She also spoke about the importance of getting the business community "back on board." She said the State of West Virginia has been able to get support for mental health services by redefining health for adolescents and for adults under the rubric of economic development. The reason Minnesota finally got prevention dollars at the state level in 1992 is that legislators began to look at the real cost of prison. "It's so important to really be focused and strategic on this early development and putting forth what the real costs are" of not addressing infant mental health issues. But it's not being done. "We're scared instead of being strategic," she said.

She closed by saying, "I did not grow up in Minnesota. I have, like some of you, a great sense of urgency on this issue, and I must say I get very frustrated with the Minnesota process. I cannot tell you how important these issues are, because Minnesota for years has been very comfortable and always likes to hear when we go to conferences about how good we are in Minnesota. Well folks, we haven't had the problems that other states have had. It's only been in the last ten years or so that we're really had to deal with some of the diversity issues, some of the poverty issues that other states have had to wrestle with. And if it isn't a clue to folks, we have pockets of poverty in Minneapolis on par with Louisiana and Mississippi. Part of our challenge, a huge problem, is for us to recognize how race and culture affect policy. We are not reexamining our challenge."

Finally, she encouraged conference participants to look at the mental health ombudsman book, *Why do we Wait?*

After Ranum finished speaking, Wattenberg jokingly wondered if the legislature would respond positively to children's mental health needs if the issue was referred to as "roads, bridges and light rail implications for 0-3." She then asked, "Why has it been so difficult for us to put child welfare in its broadest sense, the welfare of children, at the top of the agenda? The slim budget figures for family and children's services tell the story. We had a conversation at the 1999 legislature in which it was said, we have to be very careful about prevention. We might cast the net too wide and therefore incur the obligation to respond to families that are not at the very highest risk. Despite the rhetoric for prevention we are still crisis oriented. I think we have a lot of work to do on this issue."

Closing Comments

Anne Gearity emphasized that we need to have current assessment skills, saying we need to read more journals and keep abreast of current research. "We are not taking ourselves seriously. If we are to develop a new paradigm, and developing new policy strategies, we've got to get smart, we have to secure the newest research, and base our work on the newest understanding of the issues. We've got to give them the data that demonstrates that we are doing our side of the contract. We've got to keep up; we've got to keep being smart." She added, "We need to be talking about how to apply this research so that the policy/practice tension is a constantly positive one to both sides."

Dr. Kathryn Barnard, too, underlined the importance of keeping up with the literature, urging practitioners to ask for consultation with families whom they have difficulty engaging. "When I began to see that this Early Head Start program was not reaching families, I headed for the literature," she said. She noted some interesting alternative methods, including research that shows acupuncture is very effective in treating depression, and research showing weekly massage during pregnancy prevents postpartum depression. Lunde and Fields of the University of Miami collected depression symptoms with a symptom checklist instrument, did biochemical studies in those mothers, and then compared them with mothers who weren't depressed. Those mothers with symptom checklist scores at the cutoff also had the biology of depression. They had elevated epinephrine and low dopamine. Their babies also showed the same derangement. "Well then, when you begin to understand brain development and how too much cortisol interferes with the wiring and the synaptic transmission, it becomes a very complex issue, and we need to try some of these things. Let's let women who are pregnant sign up for the massage study. Who wouldn't want a weekly massage?...I think we need to try a lot of things and not go for a state-wide massage program, but try some things and see how they work. ...What would happen maybe if we gave [child care providers] a massage? Weekly? It would be interesting to try."

She then described an intervention with Early Head Start, a new program called PlayWorks. Child development staff brought about eight families with whom they had not been able to make progress in to the center four hours a day, three days a week. Staff reported that the first day the parents came in they headed for the couch or the telephone, so they began to really structure the four-hour period . In the first half-hour, all these kids were under a year so they were in their cribs when they first came in. And then they went to each crib and they said "good morning" to Johnny; good morning to Susie; good morning to Harry. ...They spent some individual time with each parent and baby. And the fathers who were unemployed started coming in to the sessions too. And then they also have the idea—because this staff likes to eat—to have food available so the parents can make their own meal at lunch. Then the parents started to make friends with each other. And it was wonderful and the home visitor said, 'You know, that mother is singing to her baby now when I go on the home visit. What's going on?' Those parents loved that program."

"Many of these parents mourn a childhood they never had. They don't know what it's like to be a parent. When they began to see these child care workers enjoy taking care of the children—everybody's laughing and singing—well, they wanted to do that, and so they were doing it." She added, "I personally think that one-to-one home visiting and one-to-one therapy for some of the clients we're working with is the wrong approach...It scares them to death...they feel they're getting too intimate with the home visitor."

Dr. Barnard then said, "I'll just tell you my last intervention since you haven't walked out yet. …So, I'd been scratching my head, reading the literature, talking to everybody, you know, what are we going to do? What are we going to do? We can't continue doing the same thing. And one of the things that's been very impressive to me is this new therapy called rapid eye movement desensitization, which is very effective in helping people with post traumatic stress disorders. One of the things we do every night is re-record the experiences during the day during REM sleep, rapid eye movement sleep. Well what happens, as people tell their trauma, like being raped or loss of their loved one, therapists can take them through cascades of rapid eye movements and something gets reprogrammed in the brain. [When] they come out of this treatment, …they still remember the event but the paralyzing emotion of the rape or the trauma is recorded elsewhere in the brain. So one of the things we hope to do is begin to use some of this therapy with clients and see then if that can open them up for other therapies and work with the child."

She told of people being trained in the Tavistock Method of containment and authority in ideas. (6) "They provide containment for the mother to express her feelings, her anger, her frustration. And about six months or so into the weekly therapy, they're beginning to find that it's beginning to transfer into the relationship with the child." She noted that even a year of weekly therapy will be cheaper than the cost of keeping someone in prison.

She spoke of psychiatrist Joe Horacek, who wrote a book called *Brainstorms*, (7) which asserts that kids have difficulty regulating as a result of biochemical problems. Horacek served as a psychiatrist for men in solitary confinement, and he talked to them about their early childhood. "As you might suspect, they never ever remember having anyone in their lives that they felt was trustworthy. …One of the small steps that he made as their psychiatrist was to tell them, when you need to get a hold of me, you let the prison guard or the nurse know and I will get back to you. And he always gave them a PRN order for medication if they were anxious or couldn't sleep, and told them, 'I want you to use that.' He said over time he was amazed at how responsive they were and respectful they were of his availability."

Gearity added, "There's an amazing parallel to that story. Neurology has now decided that pain medicine should be given at the front end. [Pain medication is given immediately after surgery] so you don't habituate into pain, you don't develop the pathway. That's exactly what Kathryn is talking about. In a psychological way these are people who have developed a pathway, so we're going to interrupt the pathway. If we can provide [trustworthiness] in a reliable way at the front end, the person actually develops the trust and doesn't need us in the same way."

Conclusions

In a post-symposium discussion we were made aware of several initiatives under development in states and communities. Among the promising efforts we note the following:

- New partnerships and teams are being assembled from the medical, social services, mental health and chemical dependency treatment communities along with early childhood development specialists. The goal is to develop services to enhance early development. Two items are high on the agenda list: the need to reduce multiple placements of infants and toddlers and to improve an understanding by child welfare workers and caregivers on the meaning of young children's challenging behavior.

- Child development services are being integrated into the standard of care received by every infant and toddler in foster care. (The Chicago metropolitan area Illinois Department of Children and Family Services: Birth to Three Services Project).

- At initial court hearings, judges are encouraged to obtain consent of biological parents to release all of the child's health records in order to initiate developmental evaluations and intervention services.

- Mental health services to identify and treat mental health needs of very young children are receiving priority attention in many local communities.

- Placement alternatives where parents and infants can stay together with different degrees of supervision and intervention (foster homes, small residence with live-in supervision, developmental homes) are under development and in use experimentally.

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